MotherCare™

Improving Provider Performance— The Skilled Birth Attendant

Summary of a MotherCare Meeting
May 2-4, 2000, Washington, DC

Introduction

MotherCare has used two strategies to improve national programs to reduce maternal and newborn deaths and improve their health. These strategies are:

- **Strengthen the performance of front-line providers to provide a safe birth,** including improving their knowledge, skills, confidence, and attitudes; and

- **Enhance knowledge and change behaviors** of women/families/other community influentials and providers, **to increase responsiveness to complications** that kill the woman and baby.

The meeting of May 2-4, 2000, focused on the first of these two strategies. An objective of the meeting was to place the MotherCare efforts in the broader context of improving provider performance, and to determine how to overcome barriers noted. While accomplishments have been many, we have also found that barriers to improving provider performance are large, such as:

1. The level of skills among "skilled birth attendants" is lower than is "safe" for safe motherhood. In-service training cannot improve the skill level of trained providers to the level of competency desired in all skills.
2. Doctors influence, or have authority over, most front line providers, but they don't always participate in team training.
3. Staff transfers among hospitals and health centers or rotations throughout the various departments of one hospital, are a major barrier to the development of a team committed to saving the lives of women and newborns.

Midwives, doctors, nurses, obstetricians, and program/project officers from a variety of countries and organizations came together in the meeting to identify activities and approaches *with evaluations* that show that they improve provider performance, specifically that of the skilled birth attendant. The presence of a skilled birth attendant at labor and delivery, with transport available in case of emergency, is considered the single most critical intervention in safe motherhood, according to the Safe Motherhood Consultation of 1997. The term "skilled birth attendant" refers exclusively to people with midwifery skills (e.g., doctors, midwives, and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose and manage or refer complicated cases.

This Policy Brief is a summary of the discussions and evidence for "Improving Provider Performance: Skilled Birth Attendant", and the recommendations of participants for the best investments:

- to sustain and scale-up efforts to improve performance,
- to improve coordination among health facilities, and
- to improve relationships among different types of providers, and among providers and the community.

Successful Efforts to Improve Provider Performance

In-service competency based training works. Skills, confidence, and attitude were improved significantly among front-line providers for safe delivery through competency based training plus a system of supervisory support. These front-line providers included midwives, nurses, nurse-auxiliaries, and general practitioners. A short (2 to 4 week) team training based on protocols for normal birthing, life saving skills and family-centered maternity care and requiring demonstrated competency, improved practices up to 3 years post-training in Bolivia, Guatemala, Indonesia, Viet Nam, Morocco, and the Ukraine, and even up to 8 years in Nigeria, according to independent evaluators.

Front-line providers can provide life saving skills when given the responsibility. Unsafe abortion remains a major contributor to maternal mortality in most developing countries. In Ghana, doctors, usually located in urban hospitals distant from the majority of women, had the sole responsibility for post-abortion care. Given appropriate Post-Abortion Care (PAC) training and officially delegated the responsibility in 1996, however, Ghanaian midwives performed exceptionally well in a pilot project and their new tasks were well used by women: No procedure-related complications were reported among women managed by midwives up to two years post-training. Following PAC training, 92% of women treated in maternity homes (where midwives provide all the care) received counseling and 55% received a family planning method. In district hospitals, where midwives provide only a third of the care, 81% received counseling and 35% a family planning method. PAC training for midwives is being scaled up in Kenya and Uganda.

Life-saving Cesarean sections are often difficult for women to obtain due to distance, cost, and other reasons. Yet in Mozambique, assistant medical officers trained in major surgery, have proved they can provide Cesarean sections as safely as specialists can, by comparing outcomes for the woman and newborn. War and poverty stimulated delegation of responsibility for major surgery to alternate health staff in Mozambique in the early 1980s. Those already providing the services out of necessity were given a three-year course and if they passed a final exam, became assistant medical officers. One-year follow-up of over 10,000 surgical interventions (of which 70% were emergency) among 14 graduates found complication rates low and postoperative mortality at 0.4% and 0.1% of the emergency and elective interventions respectively. Because of this success, the Ministry of Health of Mozambique has continued training more AMOs.

Paucity of midwifery staff in a rural district in Tanzania has also stimulated implementation of training for health attendants on family planning, clinic organization, and maternal and child health care, including normal deliveries. While no evaluation data are available yet on their maternal care skills, there is low attrition because they are government employees selected from the local area, and their motivation to perform well has increased with the new status and supervision.

Audits can be a positive "training" tool. Leadership that values listening, praise, negotiation and humor, is needed to ensure that the "audit spirit" is positive and information gathered used for change, rather than blame.

Confidentiality, however, is difficult to maintain in a small facility, and death audits are notorious for finger pointing. Audits of delays, specific obstetric complications, referrals, near misses—all may be more amenable to a positive spirit. Used periodically such audits can provide information on change in a facility (e.g., use case/fatality rate with complications audit to measure change).

In Jamaica and Ghana, audits based on measuring and improving clinical practice by comparing current practices with an agreed set of criteria or standards for managing major obstetric complications is meeting with some success. Provided with data from practice audits assembled by non-medical audit assistants, facility-based providers have instituted their own corrective measures, such as a review of roles and responsibilities, training workshops on protocols and record keeping, and making protocols available. Because of the improvements, ministries of health in both Jamaica and Ghana are interested to set up audit offices to sustain and expand these activities.

In Nepal where few women deliver in a facility, maternal deaths have been mapped and the 3-delay model used to determine factors contributing to the deaths. This has lead to a program of training for auxiliary health workers to provide some basic life saving care.

What does the literature tell us: According to *Effective Health Care*, a National Health Service's Center for Review and Dissemination bulletin based on systematic review and synthesis of research on clinical effectiveness, what works in changing individual provider performance includes: interventions based on assessment of potential barriers, multi-faceted interventions versus single interventions, educational outreach (especially when combined with social marketing), and reminder systems. The widespread use of audits plus feedback and of opinion leaders had mixed effects and should be used selectively. Printed materials disseminated alone are not useful. (For further information, see *MotherCare Matters*, Improving Provider Performance—An Exploration of the Literature, August, 2000, enclosed.)

Lessons Learned From Participants' Experience

1. **Skills are needed to manage "normal" births as well as complicated births**.

2. Improving **clinical skills** is only one focus of training; as important are skills for **problem solving** and the emphasis on **behaviors that value and respond** to a client's perceived needs.

3. Making it "safe" for those in the position of being a trainer to say, "I don't know," and to learn the skills for teaching, be they clinical, problem-solving or adult-learning skills, is a necessary ingredient for successful training.

4. **Combining a continuous system of in-service training with pre-service training is key**. Pre-service training is essential for high quality maternal care service that can be sustained over time whereas in-service training is critical for upgrading clinical services, enhancing the skills of trainers, as well as promoting continuous quality improvement. Most projects have succeeded in influencing pre-service training by including the tutors (doctors, nurses and midwives) from pre-service training as trainers in the in-service training course. The curricula used in MotherCare's projects mentioned above are now part of pre-service education in Bolivia, Indonesia, Nigeria, and Uganda.

5. **A team approach to training**, including midwives, nurses, nurse auxiliaries and doctors among the trainees and trainers, enables the use of the skills acquired in training, helps

coordinate referrals, communications, and establishes a social norm for good practices and appropriate values within and between facilities. This was witnessed in MotherCare sites in Bolivia and Indonesia.

6. On-site or local training can help retain staff: In Ghana, resident obstetricians trained through a course involving a community rotation have remained in country up to 5 years post-residency. Prior to incorporating the rotation, those trained as specialists were sent abroad and most remained abroad post-training.

7. **Peer audits of practices post-training** provides the continual contact and feedback needed to sustain use of newly acquired practices. Midwives in Indonesia have established a peer review and continuing education program of their peers through a local chapter of the Indonesian Midwifery Association.

8. **Delegation of responsibility** requires strict guidelines, selection of candidates by informal qualifications (as well as some formal qualifications), such as high moral character, and continuous monitoring to ensure good performance and outcomes.

Conclusion

The focus on in-service training for safe motherhood is shifting, as curricula and examples of their success are now available from several countries. The spotlight now moves to **pre-service training** to sustain the gains already made and scale up the successes, although in-service training must continue to update clinical knowledge and skills among those already in practice. Other strategies beyond those of training contribute to improving provider performance and demand attention:

- **administrative** strategies such as enabling systems (supervision, supplies and logistics, and functional referral networks),

- **economic** strategies like incentives aimed at increasing motivation, and

- **regulatory strategies** that enforce certain practices or establish requirements.

Given the paucity of skilled birth attendants in rural areas of many countries, delegation of responsibility to alternate providers, plus competency-based training and supportive supervision, must be considered. To further ensure availability of skilled birth attendants and a functioning referral system, peripheral facilities must be open 24 hours a day.

Recommendations

Best Buys for Program Sustainability

1. Invest in the political commitment and leadership needed to plan and guide a continuous training strategy and system at national and regional levels. Don't focus on one cadre and the results of a time limited project; rather, think together with government and other donors, toward a national strategy to improve providers' skills, confidence and attitudes, and the support systems needed to enable their work.

2. Invest in a training system that begins with assessments, curricula review and development, and training of trainers, specifically for pre-service training.

3. Involve the national professional associations in the process of setting standards, norms, and guides that form the basis for all training programs.

4. Invest in the health system reforms that reconsider who pays for what, and include incentives, career ladders, deployment plan and public/private partnerships of providers.

5. Ensure performance is measured, including coverage and quality of care.

Best Buys for Health Worker/Team Sustainability

1. Through a needs assessment, determine what health workers need and what they want to change. Personal benefit will translate into ownership, a necessary element for success.

2. Invest in training that is on-site, provides for continuous contact with those trained, and ensures an enabling environment.

3. Build in the incentives to retain providers in the periphery where they are most needed.

4. Leverage improved performance through such means as licensure, accreditation, and re-accreditation, and consumer monitoring.

5. Ensure a cost-effective supervisory system, such as that used by the Indonesia Midwifery Association with peer reviews, or self-assessment.

6. Ensure that effective elements of projects are incorporated into the national program in order to build sustainability.

7. Leadership in programs that aims to continuously upgrade the training based on evidence of effectiveness and on listening to providers' concerns is much needed .

8. Ensure that health staff, including doctors, are problem and public health oriented, and listen well. The Ghana obstetric residency program with its community rotation is a step in the right direction and could serve as an example to other programs for building a public health approach for obstetricians.

Improving the Coordination Among Health Facilities

1. Create forums, representing all levels of service delivery and decision-making to share goals, barriers, information and feedback, and successes.

2. Improve coordination between private and public sectors through incorporating the private sector into national programs (e.g., Ghana, Uganda).

3. Ensure linkages between peripheral facilities and the referral levels through established meetings, supervision, referral plans, communication and transport for emergencies. An indicator of good coordination is a functioning referral (and counter-referral) system for both elective and emergency care.

4. In order to have a functioning referral system, mandate peripheral facilities provide 24-hour care.

5. Standards, protocols, guidelines (specifically for what skills are required at each level) and curricula should be uniform among educational and training faculties, professional associations, and the ministry of health.

Improving Relationships Among Different Cadres of Providers—Stress Teamwork, Collaboration, Respect, Praise and Recognition

- Clarify Job Responsibilities and Relationships

1. Clarify general and specific roles and responsibilities of different cadres of providers', including those of supervisors.

Elucidate and justify areas of responsibility for different cadres.

2. Address issues identified through needs assessment and associated with work place satisfaction among all categories of providers. Follow up conflicts/clashes between different individuals.

3. Set up regular and frequent joint meetings, with obligatory presence of all staff.

4. Motivate the members of one cadre to give praise and recognition to other cadres.

During Training

5. Train cadres together in selected aspects of pre-service and in-service training, both as trainers and trainees. For example, institutionalize the role of midwives and /or nurses to train obstetricians during pre- and in-service training. Select a general practitioner to be responsible for providing continuing education for nursing staff. Include these same providers in the continuing education programs. Whole site training also can be effective in building the relationships among different cadres.

6. Stress active, hands-on training opportunities that demonstrate the experience, skills and roles of various providers working together (e.g., use of partograph).

Audits as a Means to Improve Performance

7. Define and motivate audit committees composed of a variety of service cadres with clear-cut instructions on how to perform an audit at different levels.

8. Conduct "near miss" case audits that praise the role of various providers in saving a mother's life before going on to examine how to improve individual and team performance; include various providers in the audit, such as specialists, midwives, lab technicians, pharmacists, and community members.

Modeling Care as a Form of Training

9. Identify leaders among obstetricians as "champions" for modeling teamwork and respect for the various cadres, and for promoting the expanded role of midwives to perform various procedures.

10. Use partnerships among professional associations responsible for different cadres to promote teamwork and mutual support and respect.

11. Highlight activities of exemplary programs and facilities so that others can learn from their experience.

Increasing Motivation

12. Discuss incentives that might be within reach, such as user fees shared between all provider categories based on merit/performance, awards, and public recognition for exemplary efforts.

Other Program and Research Ideas

13. Examine the deployment system for providers, including the rotation schedules, and the effect it has on motivation and the provision of maternal care.

14. Reach outside the health sector to disseminate communication messages about acceptable quality of services.

15. Conduct and disseminate special studies that demonstrate the competency and cost-effectiveness of various types of "lower level" or alternative providers in performing skills usually the purview of physicians (e.g., midwives and manual vacuum aspiration, IUD insertion, manual delivery of placenta, and Cesareans).

Improving relationships among healthcare providers and the community:

1. Work with staff at hospital and other facilities to develop the attitudes and skills that show respect and open up communication with clients and families and other community members.

2. In pre-service and continuing education programs, incorporate ways to increase communication and counseling skills of providers.

3. Develop programs that bring the provider into the homes of community members (e.g., postpartum home visits).

4. Include the community in case reviews/audits for maternal, perinatal morbidity and mortality cases. Ensure their involvement in the accountability for teamwork and positive outcomes, and include their input and representation as part of the quality and performance improvement agendas. Steps may include the establishment of formal, ongoing relationships between community members and facilities/providers, followed by including community members in setting standards for functioning facilities, as well as publicizing these standards to the wider community.

While a skilled birth attendant is considered critical for a safer motherhood, only a little more than half of women in developing countries use a skilled birth attendant during labor and delivery, the time most vulnerable to death for both the pregnant woman and baby.

To explore the behaviors leading to use of a skilled attendant at birth, a second meeting was held **June 5-7, 2000 in Washington DC**.

Meeting Participants

Adrienne Allison, *MNH/ JHPIEGO*
Ali Bensalah, *Morocco Ministry of Health*
Alicia Ruano, *MNH/ JHPIEGO, Guatemala*
Amina Abaacrouche, *Morocco Ministry of Health*
Annette Bongiovanni, *USAID*
Annie Clark, *American College of Nurse Midwives*
Barbara Kinzie, *MNH/ JHPIEGO*
Barbara Kwast, *Consultant*
Caroline Blair, *AED*
Cindy Stanton, *MNH/ JHPIEGO*
Claudia Morrissey, *JSI/ Boston*
Collin Bullough, *University of Aberdeen/Scotland*
David Nicholas, *URC/ CHS*
Debbie Armbruster, *Consultant*
Dennis Ross-Degnan, *Harvard University*
Diana Beck, *Consultant/ American College of Nurse Midwives*
Donna Vivio, *American College of Nurse Midwives*
Edna Jonas, *Consultant*
Elizabeth Ransom, *Population Reference Bureau*
Frank Anderson, *University of Michigan*
Gaynor Maclean, *Consultant*
George J Gilson, *University of New Mexico*
Gloria Metcalfe, *Consultant/Chile*
Godfrey Mbaruku, *Mauweni Hospital/Tanzania*
Harshad Sanghvi, *MNH/ JHPIEGO*
Jeanne McDermott, *Fogarty International Center, NIH*
Jerker Liljestrand, *World Bank*
Joe Taylor, *Ministry of Health/ Ghana*
Joellen Lambiotte, *Pathfinder*
Jos van Roosmalen, *Leiden University Medical Centre/ The Netherlands*
Kai Spratt, *USAID*
Linda Ippolito, *PRIME INTRAH, UNC Chapel Hill*
Liz Goodburn, *JSI/ UK*
Lola Payne, *Consultant/ Nigeria*
Luc De Bernis, *WHO*
Mana Sonawane, *Save the Children*
Marcia Griffiths, *The Manoff Group Inc.*
Marian Abernathy, *Training and Service Delivery Improvement, Ipas*
Martha Murdock, *Family Care International*
Mary Ellen Stanton, *USAID*
Mary Kroeger, *Linkages Project/AED*
Melahi C. Pons, *MNH/ JHPIEGO*
Miguel Ugalde, *Mothercare/Bolivia*
Miriam Labbok, *USAID*
Susan Rae Ross, *CARE*
Nancy L. Sloan, *Population Council*
Nancy Russell, *MNH/ JHPIEGO*
Nguyn Van Phuong, *Pathfinder International/ Vietnam*
Pamela Bolton, *Family Care International*
Patricia Stephenson, *USAID*
Pauline Glatleider, *Consultant/ the WIN Project*
Peg Marshall, *CEDPA*
Sabry Hamza, *JSI/ Egypt*
Sandra Buffington, *Consultant/ American College of Nurse Midwives*
Staffan Bergstrom, *Karolinska Institute/ Sweden*
Susan Goldman, *Consultant/ American College of Nurse Midwives*
Theresa Shaver, *Save the Children*
Tom Leonhardt, *Consultant*
Virginia Camacho, *PAHO*
Zynia Rionda, *Consultant*

MotherCare

Adrienne Cox
Carla Chladek
Colleen Conroy
Jen Masse
Lea Teclemariam
Leslie Elder
Marge Koblinsky
Nazo Kureshy
Patricia Daunas
Suzanne Jessop

MotherCare™

JSI John Snow, Inc.
1616 N. Ft. Myer Dr., 11th Floor, Arlington, VA 22209
Tel: 703-528-7474
Fax: 703-528-7480
http://www.jsi.com/intl/mothercare

USAID
U.S. Agency for International Development
Office of Health